Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF DALLAS
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Hartford Insurance Company of the Midwest

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-0119-01

MFDR Date Received
September 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $3,298.74 minus their payment of $1,336.90 there is still an outstanding balance of $1,961.84."

Amount in Dispute: $1,961.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Other Codes included in service Codes or no modifiers/HCPCS, also, no CPT code charges calculate as outliers"

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	Outpatient Hospital Services	$1,961.84	$203.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 22, 2011
   - W1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. FOR

QUESTIONS REGARDING THIS ADJUSTMENT. PLEASE CALL QMETRIX AT 1-800-833-1993

- W1 – WORKERS' COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES ARE INCLUDED IN THE VISIT RATE.

Explanation of benefits dated September 1, 2011

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT FOR RE RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THISTIME. BILL HS BEEN PAID ACCORDING TO PPO CONTRACT.

Issues

1. Is the claim adjustment code 45 supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits dated September 1, 2011, the carrier reduced the medical bill using code 45 "CHARGES EXCEED FEE SCHEDULE MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT." No documentation was found to support that a contract exists between the parties, nor can the division establish what type of contract - Informal or Voluntary pursuant to Texas Labor Code §413.011 (d-1) through (d-3), or Health care Certified Network Texas Insurance Code §1305 - was allegedly accessed. The division further notes that Texas Labor Code §413.011 (d-1) through (d-3) regarding informal and voluntary networks for the type of service in this dispute expired on December 31, 2010. The division concludes that reduction code 45 is not supported, for that reason; the services in dispute will be reviewed pursuant to the applicable division fee guidelines.
2. Because the respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution, the division finds that the 45 claim adjustment code is not supported.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A4565 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 88305 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $36.48. This amount multiplied by 60% yields an unadjusted labor-related amount of

$21.89. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $21.27. The non-labor related portion is 40% of the APC rate or $14.59. The sum of the labor and non-labor related amounts is $35.86. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $35.86. This amount multiplied by 200% yields a MAR of $71.72.

- Procedure code 88311 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0342, which, per OPPS Addendum A, has a payment rate of $11.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $6.62. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $6.43. The non-labor related portion is 40% of the APC rate or $4.42. The sum of the labor and non-labor related amounts is $10.85. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $10.85. This amount multiplied by 200% yields a MAR of $21.70.
- Procedure code 73130 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $26.25. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $44.27. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $44.27. This amount multiplied by 200% yields a MAR of $88.54.
- Procedure code 97597 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0015, which, per OPPS Addendum A, has a payment rate of $103.14. This amount multiplied by 60% yields an unadjusted labor-related amount of $61.88. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $60.12. The non-labor related portion is 40% of the APC rate or $41.26. The sum of the labor and non-labor related amounts is $101.38. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $101.38. This amount multiplied by 200% yields a MAR of $202.76.
- Procedure code 96365 is unbundled. This procedure is a component service of procedure code 99285 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.81. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $15.36. The non-labor related portion is 40% of the APC rate or $10.54. The sum of the labor and non-labor related amounts is $25.90. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $25.90. This amount multiplied by 200% yields a MAR of $51.80.
- Procedure code 96374 is unbundled. This procedure is a component service of procedure code 99285 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 96376 is unbundled. This procedure is a component service of procedure code 96376 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of $329.54. This amount multiplied by 60% yields an unadjusted labor-related amount of $197.72. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $192.10. The non-labor related portion is 40% of the APC rate or $131.82. The sum of the labor and non-labor related amounts is $323.92. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement

amount for this line is $323.92. This amount multiplied by 200% yields a MAR of $647.84.

- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1580 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1670 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 1670, which, per OPPS Addendum A, has a payment rate of $230.10. This amount multiplied by 60% yields an unadjusted labor-related amount of $138.06. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $134.14. The non-labor related portion is 40% of the APC rate or $92.04. The sum of the labor and non-labor related amounts is $226.18. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $226.18. This amount multiplied by 200% yields a MAR of $452.36.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 90714 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is $1,540.47. This amount less the amount previously paid by the insurance carrier of $1,336.90 leaves an amount due to the requestor of $203.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $203.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $203.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.